DEPARTMENT OF HE ALTH AND HUMAN SERVICES
CENTERS FOR MEDI CARE & MEDICAID SERVICES

PRINTED: 05/07/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G159	A. BUILDING _____ B. WING _____	04/25/2008

NAME OF PROVIDER OR SUP LIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 02	5613 6TH STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMA RY STATEMENT OF DEFICIENCIES (EACH DEF CIENCY MUST BE PRECEDED BY FULL REGULATOI Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COM MENTS A recertificati on survey was conducted from April 24, 2008, thr ugh April 25, 2008 using the fundamental survey process. A random sample of three client s was selected from a residential population of five females with mental retardation and other dis abilities. The survey findings were based on obs ervations in the group home and at two day prog arms, interviews and a review of records, inclu ding unusual incident reports.	W 000	Received 5/16/08 LPW GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 114	483.410(c)(4) CLIENT RECORDS Any individua who makes an entry in a client's record must m ake it legibly, date it, and sign it. This STAND/ RD is not met as evidenced by: Based on inte rview and record review, the facility failed to ensu e that each client's records were signed for on e of three clients (Client #1) included in th e sample. The findings i nclude: 1. Review of the agency's Unusual Incident Log was conducte d on April 24, 2008 at 11:23 AM. An incident re port dated March 25, 2008 revealed that Client #1 reported to her 1:1 counselor that she had a tiny cut on her left finger. Another incident repor t dated October 14, 2007, revealed Client #1 did n ot receive her psychotropic medications t hat was scheduled to be administered for her "bed time dosage." Further review of the log revealed investigative summaries fo r the aforementioned incidents. The investigative s ummary regarding the March 25, 2008 incident failed to evidence the date and signature of t he Incident Management	W 114	1. The IMC will sign incident reports and summaries to indicate that she has reviewed them.	6/16/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Director of Disability Svcs 5/16/08

Any deficiency statement endin g with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providin g it is determined that other safeguards provide suffic ent protection to the patients. (See instructions.) Except for nursing homes, the findings stated above a re disclosable 90 days following the date of survey wh ether or not a plan of correction is provided. For nursing homes, the above findings and plans of correct on are disclosable 14 days following the date these d ocuments are made available to the facility. If deficiencies are cited, an approved plan of correction is r quisite to continued program participation.

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W 114	Continued From page 1 Coordinator's (IMC) review. Additionally, review of the investigative summary for the October 14, 2008 incident also failed to evidence the date and signature of the Incident Management Coordinator's (IMC) review. Interview with the QMRP on April 24, 2008 at 1:20 PM revealed that the results of the investigations were forwarded to the facility's Incident Management Coordinator (IMC) for review. Although the the QMRP indicated that the investigations were forwarded to the IMC, there was no documented evidence that the investigation had been reviewed, signed or dated. 2. Review of Client #1's medical book on April 25, 2008 at 3:29 PM revealed a Health Management Care Plan dated April 14, 2008. Continued review of the plan revealed there was no documented evidence that it had been signed by the facility's nurse. Further review of Client #1's record revealed a "Community & Home Life Assessment" dated May 23, 2007 also failed to evidence the signature of the Qualified Mental Retardation Professional (QMRP). It should be noted that the assessment had a designated line at the bottom of the form requiring a signature and date.	W 114	2. The QMRP will sign each Community Life Assessment, and the Nurse will sign each Health Care Management Plan to indicate that they have been reviewed.	6/16/08
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 120	The QMRP will inform the Day Program in writing that the client needs to have an individualized behavior support plan developed to support her needs while she is present there. The QMRP will include language in the letter requesting that day staff be trained in using and documenting the behavior support plan.	6/16/08

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W 120	Continued From page 2 review, the facility failed to ensure that outside services met the needs of one of the three clients (Client #2) included in the sample. The findings include: Observation of Client #2 at the day program on April 25, 2008, at 11:35 AM revealed the client in her treatment area seated on a sofa. At 11:38 AM, staff repeatedly asked the client to stand up, both verbally and using sign language, in order to engage the client in an activity (completing a puzzle) at the table. The client however, refused. At 11:40 AM, the staff was again observed to attempt to engage Client #2 in an activity but the client refused. At 11:45 AM, at the request of the staff, the behavior specialist entered the treatment room. The behavior specialist asked Client #2 to move to the table, but again the client refused. It should be noted that the staff member revealed that Client #2's behavior of refusing to leave the sofa to join in activities at the table was a recurrent behavior. At 11:46 AM, Client #2 was observed to rub her head and shake her head up and down, while making soft verbal sounds. At 11:47 AM, the staff member again asked Client #2 to stand up and also asked the client if she wanted something to drink. The staff member offered Client #2 a cup of water but the client refused the water and refused to stand. At 11:52 AM and 11:54 AM, staff asked Client #2 to please stand up again. The client refused. At 11:56 AM, the staff member was observed to engage the client with a puzzle while seated at the sofa. At 12:00 PM, the speech pathologist came into the treatment room and assisted the client off of the sofa with the help of the Individual Program Plan (IPP) coordinator.	W 120		

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W 120	Continued From page 3 At 12:01, Client #2 was observed to be engaged in completing the puzzle while at the table. At 12:04 PM, the client was observed to move from the table to sit back on the sofa. At 12:05 PM, Client #2 came to the surveyor and grabbed the surveyor's hand in order to place it on her head. Staff told the client "no" and asked her to come back to the table, but the client opted to go back to the sofa. At 12:20 PM, Client #2 was observed rubbing the back of her head. At 12:34 PM, the client was observed rubbing her face. At 12:35 PM, the client was observed with her hands in front of her face while moving her fingers. The client was also observed to intermittently move her mouth from side to side while puckering her lips, shake her head and rub the back of her head. Interview was conducted with the IPP coordinator on April 25, 2008 at 12:10 PM to ascertain if Client #2 had a Behavior Support Plan (BSP). According to the IPP coordinator, the day program had a BSP but it expired on January 28, 2008. Upon review of the expired plan, it was revealed that the residential provider developed plan. The expired plan was designed to be implemented at the residential facility. Review of the residential BSP on April 25, 2008, at approximately 12:13 PM revealed the plan was developed to assist the client with reducing target behaviors of repetitive scalp rubbing and hair pulling and repetitive face rubbing. Continued interview with the IPP coordinator on April 25, 2008 revealed that the day program had not developed a BSP to be implemented at the day program. Additionally, after being questioned about the residential BSP, the IPP coordinator	W 120		

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W 120	Continued From page 4 and the behavior therapist revealed that the residential plan was not being implemented at the day program. Interview with the classroom staff on April 25, 2008 at 12:20 PM verified that the plan had not been implemented in the treatment room. It should be noted that additional interview with the classroom staff revealed Client #2 was new to the day program and began on January 2, 2008. At the time of the survey, the facility failed to ensure Client #2's behaviors were being consistently managed while at the day program.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for two of the three clients (Clients #2 and #3) included in the sample. The findings include: The facility failed to provide evidence that informed consent was obtained from each client and/or her legal guardian for the use of their psychotropic medication.	W 124		

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W 124	Continued From page 5 1. Observation of the evening medication administration on April 24, 2008 at approximately 4:48 PM revealed Client #2 received medications including Clonidine. Interview with the medication nurse during the medication administration revealed the aforementioned medication was used to address the client's behaviors. Interview with the Residential Director (RD) on April 22, 2008 at 8:48 AM revealed that Client #2 did not have the capacity to give informed consent for the use of her medications and habilitation services. The RD's statement was verified on April 25, 2008 at 4:37 PM through review of Client #2's psychological assessment dated June 30, 2007. According to the assessment, Client #2 "does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters due to profound mental retardation. She can not execute a durable power of attorney." Continued interview with the RD on April 24, 2008, further revealed that Client #2 did not have a legal guardian. The RD revealed that Client #2 had a guardianship hearing next week (week of April 28, 2008). At the time of the survey however, the facility failed to provide evidence that informed consent was obtained from Client #2 and/or a legally authorized representative for the use of her psychotropic medications. 2. Observation of the evening medication administration on April 24, 2008 at approximately 5:00 PM revealed Client #3 received medications including Clonazepam, Clonidine, Paroxetine and Abilify. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to	W 124	1. Client #2's guardian will be provided with written information on her medical treatment plans, and the QMRP will request the guardian to provide written consent for the treatments. 6/16/08 2. Client #3's sister is her medical decision maker. A package with information on her medical treatments will be provided to her, and the QMRP will request her written consent for such treatments. 6/16/08	

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W 124	Continued From page 6 address the client's behaviors. Interview with the Residential Director (RD) on April 22, 2008 at 8:48 AM revealed that Client #3 did not have the capacity to give informed consent for the use of her medications and habilitation services. The RD's statement was verified on April 25, 2008 at 7:23 PM through review of Client #3's psychological assessment dated June 3, 2007. According to the assessment, Client #3 "does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters due to moderate mental retardation. Continued interview with the RD on April 24, 2008, further revealed that Client #3 did not have a legal guardian. At the time of the survey however, the facility failed to provide evidence that informed consent was obtained from Client #3 and/or a legally authorized representative for the use of her psychotropic medications.	W 124		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policies that ensured the client's health and safety, for one of three clients (Client #1) included in the sample. The findings include: 1. Review of the incident reports on April 24,	W 149	1. The QMRP will ensure that staff who do not follow the policy for notifications receive both retraining and disciplinary action if appropriate. 6/16/08	

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W 149	Continued From page 7 2008 at 11:23 AM revealed an incident involving Client #1 dated March 25, 2008. According to the incident report, Client #1 reported to her 1:1 counselor that she had a tiny cut on her left finger. Review of the "Incident Summary Report" dated March 25, 2008 revealed that staff on duty the previous evening (March 24, 2008) had indicated that Client #1 had a slight injury to her hand. Further review of the "Incident Report Summary" revealed a recommendation was made for disciplinary action to the 1:1 staff for failing to complete an incident report or notifying the supervisor prior to the end of his shift. Interview with the Residential Director (RD) on April 24, 2008 at 1:13 PM revealed that each employee was responsible for filling out an incident report and questionnaire before leaving their shift. Continued interview with the RD revealed if the incident was a reportable incident and the client did not need immediate medical care, the medication nurse would examine the client upon his/her arrival. Review of the facility's "Incident Management" policy on April 24, 2008 revealed that any staff person who witnesses, discovers or is informed of an incident should complete an incident report. Additionally, the policy states that the staff are responsible for notifying family members, the nurse, the Qualified Mental Retardation Professional, RD, and the Director of Disability Services. At the time of the survey, the facility failed to provide evidence that the incident management policy and protocol were implemented as outlined.	W 149		

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W 149	Continued From page 8 2. On October 14, 2007, an incident report involving Client #1 revealed the client did not receive her psychotropic medications that was scheduled to be administered for her "bed time dosage." Continued review of the incident report revealed an investigation was conducted by the Qualified Mental Retardation Professional (QMRP). There was no documented evidence that the investigation had been reviewed. Interview with the QMRP on April 24, 2008 at 1:20 PM revealed that the results of the investigations were forwarded to the facility's Incident Management Coordinator (IMC) for review. Although the the QMRP indicated that the investigations were forwarded to the IMC, there was no documented evidence that the investigation had been reviewed. Review of the facility's "Investigative Incidents" policy on April 25, 2008 will review and approve Investigation of reportable incidents completed by the RDs/QMRPs within 48 hours of submission. At the time of the survey, the facility failed to provide evidence that the Investigative incident management policy and protocol were implemented as outlined.	W 149	2. The IMC will sign each incident report and/or investigation to indicate that she has reviewed them.	6/16/08
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	W 153	The QMRP will ensure that the RD and staff are retrained on the incident management and reporting policy and protocol, and specifically the policies on reporting incidents to the administrator and state officials, among others.	6/16/08

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W 153	Continued From page 9 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse and injurious of unknown source were immediately reported to the administrator or to other officials in accordance with State law, for two of the five clients (Client #3 and #5) that resided in the facility. The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports and corresponding investigative reports on April 24, 2008, beginning at 9:45 AM and on April 25, 2008 beginning at 2:44 PM revealed the following: a. On July 3, 2007, staff reported that Client #3 revealed she was pushed by Client #2. The report indicated that the client fell. Continued review of the facility's incidents failed to provide evidence that the incident was reported immediately to the administrator or to other officials in accordance with State law. b. On August 31, 2007 staff reported observing Client #5 with reddish marks on the lower part of her neck. Continued review of the facility's incidents failed to provide evidence that the incident was reported immediately to the administrator or to other officials in accordance with State law. At the time of the survey, the facility failed to provide evidence that the administrator and/or other officials were immediately notified of the aforementioned incidents as required.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF	W 154		

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W 154	Continued F om page 10 CLIENTS The facility n ust have evidence that all alleged violations are thoroughly investigated. This STAND RD is not met as evidenced by: Based on int rview and record review, the facility failed to ensu re that all allegations of abuse and injuries of un known origin were thoroughly investigated, for three of the five clients (Clients #2, #3, and #5) that resided in the facility. The findings nclude: Interview with the facility's Qualified Mental Retardation P rofessional (QMRP) and review of the facility's in cidents reports and corresponding investigative r eports on April 24, 2008, beginning at 9:45 AM an d on April 25, 2008 beginning at 2:44 PM revealed the following: a. On July 3, 2007, staff reported that Client #3 revealed she was pushed by Client #2. The report indicat d that the client fell. Continued review of the acility's incidents failed to provide evidence that the incident was investigated. b. On Octob r 29, 2007 staff reported noticing a bandage on t e back of Client #3's neck. Upon removal of th bandage staff observed an open area. Contin ed review of the facility's incidents revealed the QMRP completed an investigation for the aforen entioned incident on November 2, 2007. Review of the corresponding investigation revealed anot her client had "an open area which appears to be similar." There was no indication about the outc ome of the correlation between Client #3's inj ry and that of the other client that	W 154	The Director of Disability Services will ensure that the QMRP and staff are retrained on facility incident management policies, including reporting, investigating, and review with all involved people.	6/6/08

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W 154	Continued From page 11 was mentioned. Additionally, at the time of the survey, the facility failed to provide evidence that an interview was conducted with the the staff member that initially observed the injury as a part of its investigation. c. On October 29, 2007 staff reported discovering a sore/scrape on Client #5's right hand. Review of the investigation report revealed that there was another client with a "similar" open area. There was no indication about the outcome of the correlation between Client # 5's injury and that of the other client that was mentioned. d. On November 6, 2007, staff reported noticing a long bruise going down the center of Client #2's chest. Continued review of the facility's incidents revealed the facility failed to provide evidence that the aforementioned injury was investigated. e. On August 31, 2007, staff reported that Client #5 was observed to have a reddish mark on the lower part of her neck. Continued review of the facility's incidents revealed the facility failed to provide evidence that the aforementioned injury was investigated. f. On September 12, 2007, staff reported that Client #2 was scratched by Client #5. Continued review of the facility's incidents revealed the facility failed to provide evidence that the aforementioned injury was investigated. g. On October 14, 2007, the staff reported that Client #1 did not receive her psychotropic medications scheduled to be administered for her "bed time dosage." Review of the facility's investigative report failed to evidence an interview was ever conducted with the medication nurse	W 154		

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W 154	Continued From page 12 scheduled to administer the medications on the aforementioned date as a part of its investigation.	W 154		
W 156	483.420(d)(4 STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the required investigations were reviewed by the administrator or designee within five working days, for two of the five clients (Clients #3 and #5) that resided in the facility. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports and corresponding investigative reports on April 24, 2008, beginning at 9:45 AM and on April 25, 2008 beginning at 2:44 PM revealed the following: a. On October 29, 2007 staff reported noticing a bandage on the back of Client #3's neck. Upon removal of the bandage staff observed an open area. Review of the corresponding investigative report revealed that the Qualified Mental Retardation Professional (QMRP) completed the investigation on November 2, 2007. There was no evidence that the results of the investigation were reviewed by the administrator or designee. b. On October 29, 2007 staff reported discovering a sore/scrape on Client #5's right	W 156	See responses to W114, W149, W153, and W154.	6/16/08

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W 156	Continued From page 13 hand. Continued review of the facility's incidents revealed the QMRP completed an investigation for the aforementioned incident on November 2, 2007. There was no evidence that the results of the investigation were reviewed by the administrator or designee. c. On November 20, 2007, staff reported that after Client #5 got out of the bathtub, it was discovered that the client had blood on her right arm. Review of the corresponding investigative report revealed that the QMRP completed the investigation on November 27, 2007 (seven days after the incident). There was no evidence that the results of the investigation were reviewed by the administrator or designee. d. On December 4, 2007, staff reported noticing a scratch under Client #5's left eye. Continued review of the facility's incidents revealed an investigation for the aforementioned incident on December 18, 2007 (fourteen days after the incident). At the time of the survey, the facility failed to provide evidence that the results of the aforementioned investigations were reviewed as required.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment	W 159		

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W 159	Continued F om page 14 program wa integrated, coordinated and monitored b the Qualified Mental Retardation Professiona (QMRP). The findings include: 1. The QMF P failed to ensure that as soon as the Interdisc plinary Team (IDT) formulated each client' s Indi dual Program Plan (IPP), clients received cor inuous active treatment, consisting of needed in erventions and services. (See W249) 2. The QMR P failed to ensure that outside services met the needs of each client. (See W120) 3. The QMR P failed ensure that each client's self medication p ogram was effectively monitored. Observation of the evening medication administratio on April 24, 2008 at approximately 5:00 PM reve aled Client #3 assisted the medication n ree with the administration of her medications. The client was observed to bring a cup of water t the medication room (upon verbal request) and ake the medication cup from the nurse indepe dently to take her medications. Review of Cli nt #3's record on April 25, 2008 at 7:28 PM reve iled the client had her Individual Support Plan ISP) meeting on July 17, 2008. Interview with the QMRP on April 25, 2008 and further review of Client #3's record revealed that at the time of he ISP meeting, the interdisciplina y team recommended several program goal . The goals identified and documented i the ISP included goals to increase her fitness lev l, improve her community	W 159	1. The QMRP will ensure that as soon as the IDT formulates the IPP, the IPP will be imple nented and documented. 2. See response to W120. 3. The QMRP will prepare an IPP to furth er the client's ability to self medicate. The prog am will be implemented, documented, and review d at least monthly by the QMRP.	6/16/08 6/16/08 6/16/08

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W 159	Continued from page 15 living/survival skills, and increase her cognitive skills. Continued review of Client #3's ISP failed to identify a program that specifically dealt with increasing her ability to self-medicate. Additional review of Client #3's record on April 25, 2008 at 6:57 PM revealed a self-medication assessment dated July 17, 2007. Review of the assessment documented that Client #3 was to continue with her self-medication program. Interview was conducted with the Director of Residential Services on April 25, 2008 at approximately 7:30 PM to ascertain Client #3's exact self-medication program objective and to ascertain information regarding the monitoring of the program. Continued interview with the Director of Residential Services and review of Client #3's record failed to provide evidence of the exact objective and failed to provide evidence that the client's program was being monitored by the QMRP. 4. The QMRP failed to ensure the facility's Human Rights Committee (HRC) reviewed/approved Behavior Supports Plans for Clients #2 and #3. [See W262]	W 159	4. The QMRP will ensure that the Human Rights Committee reviews and approves the the Behavior Supports Plans for clients #2 and #3.	6/16/08
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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W 249	Continued From page 16 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each client received continuous active treatment services, including needed interventions, for two of the three clients (Clients #2 and #3) included in the sample. The findings include: The facility failed to ensure that each client's formal program objectives were consistently implemented. 1. Review of Client #2's records on April 25, 2008 at 5:23 PM revealed the client had an Individual Support Plan (ISP) dated July 17, 2007. Interview with the Qualified Mental Retardation Professional (QMRP) on April 25, 2008 and further review of Client #2's record revealed that at the time of the ISP meeting, the interdisciplinary team recommended program objectives including the following: Client #2 will independently observe privacy during personal care routines on 80% of trials per month for three consecutive months. Interview with the Director of Disability Services on April 25, 2008 and further review of the client's record failed to provide evidence that the objective had been implemented. 2. Review of Client #3's records on April 25, 2008 at 7:28 PM revealed the client had an ISP dated July 17, 2007. Interview with the QMRP on April 25, 2008 and further review of Client #3's record revealed that at the time of the ISP meeting, the interdisciplinary team recommended program objectives including the following:	W 249	1. The QMRP will ensure that programming will be implemented as soon as it is formulated by the IDT. 2. The QMRP will ensure that programming is implemented and documented in the frequency specified.	6/16/08 6/16/08

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W 249	Continued from page 17 Given verbal cues, Client #3 will correctly dial a phone number on a telephone keypad on 80% of the trials per month for three months. Interview with the QMRP on April 25, 2008 at approximately 4:35 PM and further review of the client's record revealed data was collected for the months of September 2007, October 2007, and April 2008 only. At the time of the survey, the facility failed to provide evidence that Client #3 was given the opportunity to participate with the aforementioned program objective in the frequency required.	W 249		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Client #2 and #3's Behavior Support Plans had been reviewed and approved by their Human Rights Committee (HRC). The finding includes: 1. Observation of the evening medication administration on April 24, 2008 at approximately 4:48 PM revealed Client #2 received medications including Clonidine. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors.	W 262	1. The QMRP will place the HRC minutes and attendance sign-in sheet in the facility's Human Rights record book.	6/6/08

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W 262	Continued From page 18 Review of the facility's Human Rights Committee (HRC) minutes on April 24, 2008 beginning at 2:30 PM revealed a HRC meeting was scheduled to review Client's #2's Behavior Support Plan (BSP), which incorporated the client's psychotropic medications. However, at the time of the survey the facility failed to provide evidence of the date that the committee met to review/approve Client #2's BSP. Interview with the Qualified Mental Retardation Professional (QMRP) on April 24, 2008, at 2:35 PM verified that there was no documented evidence of a "signature sheet" attached to the HRC meetings. Although the QMRP indicated that all of the residents plans were reviewed in January 2008 and again in March 2008, at the time of the survey, the facility failed to provide evidence of when its HRC reviewed and approved Client #2's BSP. 2. Observation of the evening medication administration on April 24, 2008 at approximately 5:00 PM revealed Client #3 received medications including Clonazepam, Clonidine, Paroxetine and Abilify. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. Review of the facility's Human Rights Committee (HRC) minutes on April 24, 2008 beginning at 2:30 PM revealed a HRC meeting was scheduled to review Clients #3's Behavior Support Plan (BSP), which incorporated the client's psychotropic medications. However, at the time of the survey the facility failed to provide evidence of the date that the committee met to	W 262	2. See response to #1 above.	6/16/08

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W 262	Continued From page 19 review/approve Client #3's BSP. Interview with the Qualified Mental Retardation Professional (QMRP) on April 24, 2008, at 2:36 PM verified that there was no documented evidence of a "signature sheet" attached to the HRC meetings. Although the QMRP indicated that all of the residents plans were reviewed in January 2008 and again in March 2008, at the time of the survey, the facility failed to provide evidence of when its HRC reviewed and approved Client #3's BSP.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for two of the three clients (Client #2 and #3) included in the sample. The finding includes: 1. Observation of the evening medication administration on April 24, 2008 at approximately 4:48 PM revealed Client #2 received medications including Clonidine. Interview with the medication nurse during the medication administration revealed the aforementioned medication was used to address the client's behaviors.	W 263	1. See response to W124.	6/10/08

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W 263	Continued From page 20 Interview with the Residential Director (RD) on April 22, 2008 at 8:48 AM revealed that Client #2 did not have the capacity to give informed consent for the use of her medications and habilitation services. The RD's statement was verified on April 25, 2008 at 4:37 PM through review of Client #2's psychological assessment dated June 20, 2007. According to the assessment, Client #2 "does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters due to profound mental retardation. She can not execute a durable power of attorney." Continued interview with the RD on April 24, 2008, further revealed that Client #2 did not have a legal guardian. The RD revealed that Client #2 had a guardianship hearing next week (week of April 28, 2008). Further review of Client #2's record on April 25, 2008 at approximately 4:40 PM revealed that the client, in addition to taking psychotropic medications, also had a Behavior Support Plan (dated January 28, 2008) to address her behaviors. At the time of the survey however, the facility failed to provide evidence that consent was obtained for the use of the psychotropic medication and Behavior Support Plan (BSP) that were designed/conducted to reduce Client #2's behaviors. 2. Observation of the evening medication administration on April 24, 2008 at approximately 5:00 PM revealed Client #3 received medications including Clonazepam, Clonidine, Paroxetine and Abilify. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to	W 263	2. See response to W124.	6/16/08

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W 263	Continued From page 21 address the client's behaviors. Interview with the Residential Director (RD) on April 22, 2008 at 8:48 AM revealed that Client #3 did not have the capacity to give Informed consent for the use of her medications and habilitation services. The RD's statement was verified on April 25, 2008 at 7:23 PM through review of Client #3's psychological assessment dated June 20, 2007. According to the assessment, Client #3 "does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters due to moderate mental retardation. Continued interview with the RD on April 24, 2008, further revealed that Client #3 did not have a legal guardian. Further review of Client #3's record on April 25, 2008 at approximately 7:17 PM revealed that the client, In addition to taking psychotropic medications, also had a BSP (dated August 16, 2007) to address her behaviors. At the time of the survey however, the facility failed to provide evidence that consent was obtained for the use of the psychotropic medication and BSP that were designed/conducted to reduce Client #3's behavlors.	W 263		
W 368	483.460(k)(1 DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were	W 368	The RN Supervisor will retrain the medication nurse on the policy for informing the Designated Nurse ate least five days prior to the clients' medications running low. 6/6/08	

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W 368	Continued F om page 22 administered in compliance with the physician's orders, for o e of three clients (Client #2) included in th e sample. The finding i cludes: Observation of the evening medication administratio on April 24, 2008 at approximately 4:48 PM revealed Client #2 received medications including Clo idine. At approximately 4:50 PM the medicatio nurse was observed to obtain a box from the medication cabinet for Client #2 with a label for De brox, "instill 3 drops once daily each ear." The me dication nurse informed the surveyor that he was not able to administer Client #2's Debrox because it was "not available." Continued int erview with the medication nurse revealed that the facility's designated nurse was responsible f r ordering the client's medications. On the next day at 5:29 PM, the medication nurse was interviewed prior to leaving the facility. The medication nurse was asked if Client #2's Debrox was ordered and administered. The medication nurse reveale d again that the ear drops were not available. The facility's designated nurse was present at the time and indicated that she was not aware that Client #2's Debrox needed to be refilled, becau se, at the time of the survey, the medication nurse failed to inform her. Interview with the designated nurse on April 25, 2008 at 5:33 PM revealed that it was the responsibility of the medication nurse to inform her at least five (5) days before the client's medication ru s low. The designated nurse was then overheard on the phone ordering Client #2's ear drops, two days after the medication was completed for the month.	W 368		

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W 368	Continued From page 23 Review of Medication Administration Record (MAR) on April 25, 2008 at approximately 6:00 PM revealed a Physician's Order (POS) dated March 2008. Further review of the POS revealed that the client was prescribed Debrox 15ML"instill 3 drops once daily each ear." It should be noted that Client #2's MAR revealed that she received her ear drops as prescribed prior to the medication observation on April 24, 2008. At the time of the survey, the facility failed to provide evidence that the medication prescribed by the physician for Client #2 was consistently given in compliance with the physician's orders.	W 368		

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CARECO 02	6613 6TH STREET, NW WASHINGTON, DC 20012

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R 000	INITIAL COMMENTS A relicensure survey was conducted from April 24, 2008, through April 25, 2008. A random sample of three residents was selected from a residential population of five females with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check. The finding includes: Interview with the Director of Disability Services and review of the GHMRP's personnel records on April 25, 2008, at approximately 7:35 PM revealed that the GHMRP failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and	R 125	The Human Resources Director will ensure that background checks are on file for each employee of the facility.	6/16/08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director of Disability Svcs — (X6) DATE: 5/16/08

STATE FORM 6899 VD1P11 If continuation sheet 1 of 2

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R 125	Continued From page 1 worked for three staff.	R 125		

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I 000	INITIAL COMMENTS A relicensure survey was conducted from April 24, 2008, through April 25, 2008. A random sample of three residents was selected from a residential population of five females with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports.	I 000		
I 058	3502.16 MEAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the QMRP failed to ensure modified diets had been reviewed at least quarterly by the consulting dietitian to ensure the each resident received adequate nutrition in accordance with their needs, for one of the three residents (Resident #3) included in the sample. The findings include: Observation of Resident #1 during the survey revealed the resident appeared to be overweight. Review of Resident #3's records on April 25, 2008 at approximately 6:00 PM revealed the resident's April 2008 Physician's Orders (POS) that documented the resident was prescribed a 1500 calorie decrease cholesterol and fat, increased fiber diet with no fried, spicy, or greasy	I 058	The QMRP will ensure that Nutritional Quarterly Reviews are completed and on file for each person served in the facility.	6/16/08

Health Regulation Administration

Martha H. Thompson, Director of Disability Svcs.
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 5/16/08

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I 058	Continued from page 1 foods. Continued review of Resident #3's record revealed a first quarter nutritional report dated September 3, 2007. Interview was conducted with the Director of Residential Services on April 25, 2007 at 7:16 PM to ascertain if there were any additional nutritional quarterlies following the September 3, 2007 quarterly for review. At the time of the survey, the GHMRP failed to provide evidence of any other nutritional quarterlies following the September 13, 2007 quarterly. The GHMRP failed to ensure that Resident #3 received nutritional quarterlies timely.	I 058		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on April 24, 2008 and review of the GHMRP's personnel files on April 24, 2008 at 2:39 PM revealed that the GHMRP failed to provide evidence that seven staff and four nurses had the contents of their job descriptions discussed with them at the beginning of their employment and/or annually thereafter. It should be noted that interview was conducted with the Director of Disability Services and further	I 203	The QMRP will review the position description with each staff person; the Director of Disability Services will review position descriptions with each nurse at the start of employment and at least annually thereafter.	6/6/08

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I 203	Continued From page 2 record review on April 25, 2008 additionally failed to provide evidence that employees had the contents of their job descriptions discussed with them as required.	I 203		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's personnel files on April 24, 2008 at 2:39 PM revealed the GHMRP failed to provide evidence that current health certificates were on file for one staff, one nurse, and three consultants. It should be noted that interview was conducted with the Director of Disability Services and further record review on April 25, 2008 additionally failed to provide evidence of the required physician's certifications.	I 206	The Human Resources Director will ensure that all staff and consultants have current health certificates on file.	6/16/08

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I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each resident 's records were signed for one of three residents (Resident #1 included in the sample. The findings include: 1. Review of the agency's Unusual Incident Log was conducted on April 24, 2008 at 11:23 AM. An incident report dated March 25, 2008 revealed that Resident #1 reported to her 1:1 counselor that she had a tiny cut on her left finger. Another Incident report dated October 14, 2007, revealed Resident #1 did not receive her psychotropic medications that was scheduled to be administered for her "bad time dosage." Further review of the log revealed investigative summaries for the aforementioned incidents. The investigative summary regarding the March 25, 2008 incident failed to evidence the date and signature of the Incident Management Coordinator's (IMC) review. Additionally, review of the investigative summary for the October 14, 2008 incident also failed to evidence the date and signature of the Incident Management Coordinator's IMC) review. Interview with the QMRP on April 24, 2008 at 1:20 PM revealed that the results of the investigations were forwarded to the facility's Incident Management Coordinator (IMC) for review. Although the the QMRP indicated that the investigations were forwarded to the IMC,	I 291	See response to federal deficiency W114.	6/16/08

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I 291	Continued from page 4 there was no documented evidence that the investigation had been reviewed, signed or dated . 2. Review of Resident #1's medical book on April 25, 2008 at 1:29 PM revealed a Health Management Care Plan dated April 14, 2008. Continued review of the plan revealed there was no documented evidence that it had been signed by the facility's nurse. Further review of Client #1's record revealed a "Community & Home Life Assessment" dated May 23, 2007 also failed to evidence the signature of the Qualified Mental Retardation Professional (QMRP). It should be noted that the assessment had a designated line at the bottom of the form requiring a signature and date.	I 291		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s), for two of the three residents (Residents #2 and #3) included in the sample. The finding includes: The facility failed to ensure that each client's formal program objectives were consistently implemented. 1. Review of Resident #2's records on April 25,	I 422	See response to federal deficiency W249.	6/16/08

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I 422	Continued From page 5 2008 at 5:23 PM revealed the resident had an Individual Support Plan (ISP) dated July 17, 2007. Interview with the Qualified Mental Retardation Professional (QMRP) on April 25, 2008 and further review of Resident #2's record revealed that at the time of the ISP meeting, the interdisciplinary team recommended program objectives including the following: Resident #2 will independently observe privacy during personal care routines on 80% of trials per month for three consecutive months. Interview with the Director of Disability Services on April 25, 2008 and further review of the client's record failed to provide evidence that the objective had been implemented. 2. Review of Resident #3's records on April 25, 2008 at 7:28 PM revealed the resident had an ISP dated July 17, 2007. Interview with the QMRP on April 25, 2008 and further review of Resident #3's record revealed that at the time of the ISP meeting, the interdisciplinary team recommended program objectives including the following: Given verbal cues, Resident #3 will correctly dial a phone number on a telephone keypad on 80% of the trials per month for three months. Interview with the QMRP on April 25, 2008 at approximately 4:35 PM and further review of the client's record revealed data was collected for the months of September 2007, October 2007, and April 2008 only. At the time of the survey, the facility failed to provide evidence that Resident #3 was given the opportunity to participate with the aforementioned program objective in the frequency required.	I 422		

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